Form Approved
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NOAA Health Services Aviation Questionnaire

(This information is for official and medically confidential use only and will only be released to NOAA medical personnel)

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other suggestions for reducing this burden to Health Services, NOAA Office of Marine and Aviation Operations 8403 Colesville Rd., Silver Spring, MD 20910-1282. Notwithstanding any other provisions of the law, no person is required to respond to, nor shall any person be subjected to a penalty for failure to comply with, a collection of information subject to the requirements of the Paperwork Reduction Act, unless that collection of information displays a currently valid OMB Control Number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRINCIPAL PURPOSE(S) To obtain medical data for determination of medical fitness for flight aboard aircraft flying Mission Operations on behalf of NOAA to screen and identify individuals that could be placed in a work environment (flight) with the potential to aggravated existing medical conditions.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in denial of a NOAA Aeromedical Clearance Notice which is required to fly Mission Operations aboard aircraft operated by NOAA as well as aircraft operated by other entities on behalf of NOAA with NOAA personnel on board.

****

Name: _____
Last First

Birth Date: _____ Sex: _____ _____
(mm/dd/yr) M F

Your E-Mail: _____
Your Phone: _____
SSN: _____
NOAA Program: _____
NOAA Supervisor: _____
NOAA Supervisor E-Mail: _____

Your Phone Numbers: _____ (W) _____ (H)

Emergency Contact: _____
Name Phone Relationship

GENERAL MEDICAL SCREENING

YES NO Do you have, or have you ever had: (explain any positive responses on Continuation Page)

1. **Disease of the eyes, ears, sinuses, seasonal allergies, hayfever, difficulty with clearing your ears, severe hearing loss, or pain in your ears or sinuses from diving or flying?**
2. **Chest pain, angina, heart attack, heart disease, heart murmur, palpitations, cardiac catheterizations, or pacemaker?**
3. **Hypertension, stroke, blood clots in legs, swelling in feet, or excessive fatigue with mild exertion?**
4. **Asthma, wheezing, emphysema, chronic cough, tuberculosis, collapsed lung, or shortness of breath with mild exertion?**
5. **Diseases of the bowel, ulcers, rectal bleeding, chronic abdominal pain, hernia, kidney stone, or painful or frequent urination?**
6. **Arthritis, joint deformity, chronic back pain, or limitation of use of your back or extremities?**
7. **Paralysis, weakness of muscles, seizures, epilepsy, migraine or other severe headaches, loss of consciousness, fainting spells, dizziness, or amnesia?**
8. **Mania, depression, schizophrenia, suicide attempt, alcoholism, illegal drug use, panic attacks, fear of flying, fear of heights, or fear of enclosed spaces?**
9. **Anemia, diabetes, cancer(s), arterial gas embolism, decompression sickness, severe motion sickness, surgery, hospitalization, or other chronic medical conditions not listed?**
10. **Are you currently pregnant?**
11. **Are you currently taking any medications?**
    List Current Medications: _____ _____ _____
    _____ _____ _____

*****If you have been scuba diving within 24 hours of flying, have had any dental procedures within 48 hours of flying, or are currently pregnant – YOU MUST CONSULT WITH A FLIGHT SURGEON.**

Are you aware of any other medical condition(s) that may affect your suitability for aviation duty? No Yes
If yes, please explain on the continuation page

If you have any questions, please contact the appropriate Health Services Office:

Aircraft Operations Center: 813-828-3310 x-3102 (Office) / 813-294-6703 (Cellular)
Marine Operations Atlantic: 757-441-6320 (Office) / 757-615-6619 (Cellular)
Marine Operations Pacific: 206-553-8704 (Office) / 206-409-8725 (Cellular)
Director, NMAO Health Services: 301-713-7715 (Office) / 240-478-8915 (Cellular)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment. **ANY CHANGES IN YOUR MEDICAL CONDITION SINCE YOU LAST COMPLETED THIS MEDICAL HISTORY FORM, MUST BE REPORTED TO THE NOAA AVIATION MEDICAL EXAMINER IMMEDIATELY.**

_____ _____

Employee Signature Date (mm/dd/yy)

Please submit your completed questionnaire to one of the following offices for review:

NOAA AIRCRAFT OPERATIONS CENTER
NOAA OFFICE OF HEALTH SERVICES
P.O. BOX 6829
MACDILL AIR FORCE BASE, FL 33608-0829
Secure fax (813-828-5060

NOAA DIVE CENTER
NOAA OFFICE OF HEALTH SERVICES
7600 SAND POINT WAY, NE
SEATTLE, WA 98115
Secure fax (206) 526-6506

---------- [Below section to be completed by NOAA Medical Officer] ----------
MEDICALLY CLEARED FOR AVIATION DUTY BY HISTORY: YES NO NEED MORE INFO

_____ _____
AOC / MOA / MOP Regional Director of Health Services Date (mm/dd/yy)

Name: _____

NOAA Health Services Aviation Questionnaire Continuation Page